

ELECTRONIC EXPLANATION OF PAYMENT (EOP) AGREEMENT

GROUP/BILLING PROVIDER NUMBER: _____

GROUP/BILLING NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

CONTACT: _____ **PHONE NUMBER:** _____

SUBMITTER ID: _____

VENDOR NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

VENDOR PHONE NUMBER: _____

VENDOR CONTACT: _____

I (we) request to receive Electronic Explanation of Payment (EOP) information and authorize the information to be deposited in our electronic mailbox. I (we) accept financial responsibility for costs associated with receipt of Electronic EOP information.

I (we) understand that paper-formatted EOP information will continue to be sent to my (our) mailing address as maintained at EDS until I (we) submit an Electronic EOP Certification Request Form.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

Authorized Signature: _____ **Date:** _____

Title: _____ **Internet Address:** _____

Mail form to: EDS • Attn: ECS Department • P.O. Box 244035 • Montgomery, AL 36124

FAX form to: 334-215-4272 Attn: ECS Department

FOR EDS USE ONLY

BILLING MODE: _____ **EOP MODE:** _____ **PROTOCOL:** _____

CONTACT DATE: _____ **SOFTWARE MAILED:** _____

TEST DATE: _____ **AGREEMENT DATE:** _____ **APPROVAL DATE:** _____

BEGIN DATE: _____ **END DATE:** _____

NOTES: _____
